Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

USMD HOSPITAL ARLINGTON
801 WEST I 20
ARLINGTON TX 76017

Respondent Name
COMMERCE & INDUSTRY INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-2264-01

MFDR Date Received
November 3, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are submitting this claim to Medical Disputes because the claim was denied for the correct CPT code for the implants (C1820 only) and the appeal was denied for the same reason. According to the information I was given the CPT code we are billing for the implants is correct."

Amount in Dispute: $104,776.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG did not make a payment for these dates of service as we feel the provider used the wrong CPT code (CPT1820) to charge for the implants. The charges are excessive as evidenced by the 278% mark up on the implants; however a payment needs to be made to the hospital as there are no liability issues to prevent a payment."

Response Submitted by: AIG Insurance Services, Inc., 8144 Walnut Hill Lane, Suite 1500, Dallas, Texas 75231

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2008 to June 6, 2008	Outpatient Hospital Services	$104,776.70	$11,266.49

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 220 – The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. In an explanation of benefits dated July 23, 2009, the insurance carrier reduced or denied disputed services with reason codes 45 – "Charges exceed your contracted/legislated fee arrangement," and 96 – "Non-covered charges(s)." Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute. Nor was any documentation found to support that the disputed services are not covered. These denial reasons are unsupported. Furthermore, per 133.307(d)(2)(B), "the response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." The request for medical dispute resolution was filed on November 3, 2008. No documentation was found to support that the insurance carrier had presented these denial reasons to the requestor prior to the date the request for MDR was filed. Accordingly, these newly raised denial reasons or defenses shall not be considered in this review.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $93,445.40. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code C1787 has a status indicator of N, which denotes packaged items and services with no separate APC payment. Procedure code C1787 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier

payments. Payment for separately reimbursed implantable items is addressed below.

- Procedure code C1820 has a status indicator of N, which denotes packaged items and services with no separate APC payment. Procedure code C1820 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
- Procedure code C1897 has a status indicator of N, which denotes packaged items and services with no separate APC payment. Procedure code C1897 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
- Procedure code 80051, date of service May 27, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.80. 125% of this amount is $12.25
- Procedure code 85027, date of service May 27, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.04. 125% of this amount is $11.30
- Procedure code 87641, date of service May 27, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $49.04. 125% of this amount is $61.30
- Procedure code 76001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 63650 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 40, which, per OPPS Addendum A, has a payment rate of $4,062.82. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,437.69. This amount multiplied by the annual wage index for this facility of 0.9681 yields an adjusted labor-related amount of $2,359.93. The non-labor related portion is 40% of the APC rate or $1,625.13. The sum of the labor and non-labor related amounts is $3,985.06. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $3,985.06. This amount multiplied by 130% yields a MAR of $5,180.58.
- Procedure code 63650 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 40, which, per OPPS Addendum A, has a payment rate of $4,062.82. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,437.69. This amount multiplied by the annual wage index for this facility of 0.9681 yields an adjusted labor-related amount of $2,359.93. The non-labor related portion is 40% of the APC rate or $1,625.13. The sum of the labor and non-labor related amounts is $3,985.06. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $3,985.06. This amount multiplied by 130% yields a MAR of $5,180.58.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Per §134.403(b)(2), "Implantable" means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program and recharge the implantable. Review of the submitted documentation finds that the separate implantables include:
   - "KIT PATIENT PROG SC550002" as identified in the itemized statement and labeled on the invoice as

"SCSII PAT PROGRMMING KIT" with a cost per unit of $1,190.00;

- "BATTERY GENERATOR PULSE KIT" as identified in the itemized statement and labeled on the invoice as "DUAL ARRAY RECHRGABLE IPG" with a cost per unit of $18,450.00;
- "KIT CONTACT LEAD 70CM" as identified in the itemized statement and labeled on the invoice as "SCS 70CM III LEAD" with a cost per unit of $2,390.00 at 2 units, for a total cost of $4,780.00;
- "CHARGER FOR GENERATOR KIT" as identified in the itemized statement and labeled on the invoice as "CHARGING SYSTEM" with a cost per unit of $2,990.00.

The total net invoice amount (exclusive of rebates and discounts) is $27,410.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,896.00. The total recommended reimbursement amount for the implantable items is $29,306.00.

5. The total allowable reimbursement for the services in dispute is $39,752.01. This amount less the amount previously paid by the insurance carrier of $28,485.52 leaves an amount due to the requestor of $11,266.49. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $11,266.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $11,266.49, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.